GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION

Health Certificate for Staff

NAME: _____ **SEX (Please circle one):** MALE FEMALE

DATE OF BIRTH: _____ **TELEPHONE No:** _____

ADDRESS: _____
Street **City** **State** **Zip Code**

TYPE OF PROFESSIONAL LICENSE: _____

I have examined the above-named person and certify that he/she is:

1. Free from disease in communicable form. **{Please Circle One:}** YES NO
2. In addition to a general physical health examination, the following test have been done:

   Tuberculin Test **(check one)** [ ] Tine [ ] PPD

   Date: _____ Result: _____

   Chest X-Ray, Date: _____ Result: _____

Remarks:

_____

_____

_____

_____ _____
Signature of Health Care Practitioner **Date of Examination**

_____ _____
Address of Health Care Practitioner **Telephone No.**